

The Toxic Vortex of Frustration in Nursing Practice

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Health care today is a turbulent place. As coordinating figures in patient care, nurses are seen as a social and political constant in a world of kaleidoscopic change. Still in line with the 19th century patriarchal view of caring, nurses are expected by society to remain clinically robust while adapting to disruptive changes and challenges which are often unanticipated and imposed. The potential of such challenges to undermine the quality of the care given or the health of those who provide it is all too often a secondary consideration if it is a consideration at all (RCN, 2013).

The notion of 'routine' in practice is misguided.. Any service perpetually interfacing with humanity is fraught with a diverse range of unforeseen events with different entrance and exit points demanding contingency and confounding the plans of the most proactive practitioner (Bredo, 1999). Nursing is no exception (Cowley, 1995; McKinnon, 2016a). Sound practice in nursing demands constantly adjusted physical, mental and emotional labour to meet the needs of patients (Theodosius, 2008 ; McKinnon, 2011). So when I speak of disruptive elements I am not referring to those integral to nursing practice that may require clinical priorities to be altered (e.g: a clinical emergency or grieving relatives in need of extra attention). Instead I have in mind the findings of a recent study (McKinnon, 2016b) pointing to policies, logistics, systems and behaviours which are obstructive to good processes and outcomes. Examples of these are data collection systems which place emphasis on quantity rather than quality in practice, malfunctioning equipment, insufficient stocks and supplies, eight hour a day support services for 24/7 care, allied professionals who fail to play their part, relentless waves of uncovered sick leave, poor levels of staffing and skill mix together with ways of working which do not account for practitioner need.

Such negative influences on practice are invisible to uninformed observers in politics or among the public at large. This invisibility means that as frontline practitioners, nurses are in an invidious position. As an ethically motivated process driven workforce they do not have the luxury of lowering their expectations. Rather they must 'steal' time and energy originally reserved for care; substituting their own efforts for deficits in support systems. Patient care cannot proceed without their improvisation so there are no other viable options. On the other hand, in the face of

poor care outcomes, nurses prove easy targets of misplaced blame for an unsatisfied public who feel poorly served and for managers and politicians who previously failed to listen or act on raised concerns. This in turn leads to a feeling of being undervalued.

The consequence of this has historically been termed 'low staff morale'. Once used to describe a temporary affective state among practitioners, 'low staff morale' now presents as a taken for granted norm in many nursing teams. But it is an inadequate term to describe or encompass a toxic process which threatens the integrity of a professional community.

In a contemporary context, 'low staff morale' is more accurately interpreted by Burston and Tuckett (2012:1) as 'moral distress'. Moral distress is the feeling that arises from the ethical conflict experienced when the ability to do what is right is removed from the knowledge of what is right. A distressed moral position is allied to frustration which can be defined as stemmed progress in the face of best efforts made. Frustration has been shown to act like a vortex; drawing in and fermenting other negative feelings and behaviours. Disappointment generates anger over injustice related to inequity. Delayed outcomes lead to 'workload drift' carried over to other days resulting in accelerated practitioner exhaustion and non reflective decision making (Vansteenkiste and Ryan, 2011;McKinnon, 2016b).

Frustration exerts excess 'taxation' on emotional discipline making emotional labour harder to sustain. Preoccupation with multitasking and the feeling of losing ground against a tidal wave of competing demands can disable empathy because nurses become preoccupied with their own unmet needs. Over time a loss of autonomy and self esteem leads to bitterness and cynicism along with worthlessness, despair and burnout (Lewandowski, 2003; McKinnon, 2016b). Emotional intelligence falters. Expressions of anger, as an 'end point' reaction, 'breaking through' the emotional labour 'net' in inappropriate settings can impact on fragile relationships with patients, their families and with other nurses. A survey analysis of more than 95,000 nurses and patients by McHugh et al. (2011) found a direct correlation between raised nurse dissatisfaction and low patient satisfaction. These short and long term feeling states are major contributors to poor health and increased sick leave among nurses (Vansteenkiste and Ryan, 2011) feeding a desire to leave the profession (Li et al. 2013). This is a picture of a toxic system pitching nurses against their patients and against each other.

As a nurse, I despair over the cyclical nature of these unlearned lessons and the cost to the public purse. As an academic I may talk about building resilience in the future nursing workforce. But as a patient I want to know what sort of society expects so much from its nurses yet fails to provide the means to sustain them. I hope someone is listening.

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